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THE UNIVERSITY OF ALBERTA

A Single Case Study Investigation of the Process of Change

by

David Bliss Lingley

A THESIS

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled A.Single.Case.Study..... Investigation.of.the.Process.of.Change..... submitted.by.David.Bliss.Lingley..... in partial fulfilment of the requirements for the degree of Master of Education.in.Counselling.Psychology

To My Parents

ABSTRACT

The purpose of this study was to gather ideas regarding the process of change, through application of an approach which combined open systems ideas with the Change Model of Watzlawick, Weakland and Fisch (1974). The study was exploratory in nature, using a descriptive, single case study approach. Focus was directed toward practical shifts occuring in a stated problem system, and corresponding changes in the relationship system. In addition, ideas regarding the facilitating and inhibiting aspects of the proposed model were explored. The subjects were a married couple, who sought therapy to alter the impact which his depression had upon their relationship. The treatment plan proposed by Watzlawick et. al., (1974) was implemented with modifications to correspond with open systems principles. Eleven treatment sessions were held, at which point therapy was terminated. Data regarding the impact of the treatment and status of the initial problem were gathered through a termination interview, and a follow-up interview conducted four months later.

Descriptive reports indicated that changes occured for both the presenting problem, as well as other areas of the relationship. Shifts in the process reflected a movement away from passive and reactive behaviors to more dynamic, action oriented approaches to experiences. Strengths and weaknesses in the applied model appeared dependent upon therapist perceptions and interpretations

of the model's assumptions, and their practical applications in treatment. The issue of the appropriateness of traditional research methodologies was raised in discussing future investigation of the model.

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CHAPTER I

Introduction

The purpose of this study is to investigate the assumptions of Watzlawick, Weakland and Fisch (1974) regarding persistence and change integrated with open systems concepts. As the Change Model represents a context for paradoxical interventions in psychotherapy, the contributing frameworks are reviewed. The paradox models are explored for their adaptability to an open systems approach in therapy, and implications for modifications to the change framework are suggested. A single case study approach was chosen to explore the integrated model.

Background to the Problem

All therapeutic approaches form assumptions, whether implicit or explicit, regarding the nature of problem formation and problem resolution. From these assumptions there are certain therapeutic behaviors designed to facilitate change. However, these same assumptions may also impose limitations to the encounter. While in some theories a symptom shift is accepted as evidence for therapeutic success, in others this outcome represents only the tip of the problem iceberg. Interventions employed for change are generally explicitly stated, however, 'what one should not do' is usually implicit and not directly challenged (Watzlawick, Weakland, Fisch,

Segal, Hoebel and Deardoff, 1975). Thus, techniques which may be appropriate and effective may be excluded from a model because of a theoretical bias.

Watzlawick et al (1974) suggest that human dilemmas arise not because a problem defies solutions, but rather because of the assumptions one makes about the solutions to that problem. The Change Model contains explicit assumptions regarding the relationship of persistence and change, and the nature of interventions required to effect shifts in a problem system. Research supporting the effectiveness of the model is limited to the evaluation by Weakland, Watzlawick, Fisch and Bodin (1974). While the authors intimate that there may be limitations present in their structural system, there has been no critique of the premises at this time. The focus of this study is to examine both the limitations and effectiveness of the change framework.

Purpose of the Study

The Change Model with open system's modifications was used in the therapeutic encounter. The purpose of this study was to gather information concerning the following issues:

1. To investigate the practical changes in a problem system through the use of paradoxical interventions.

2. To define these changes as first or second order system shifts.

3. To explore issues within the treatment model which facilitate or inhibit its application.

4. To explore the impact of change in one of the client's systems, in relation to the broader context of the client's life.

The data for this study were gathered by implementing the treatment model in a therapy encounter. A single case study format was used, with therapy sessions audio-taped and the transcripts analysed for relevant data. A client from the therapists practise was invited to participate in the study. Four months after termination of treatment a follow-up interview was conducted to evaluate the client's status and the impact of the treatment.

Relevance of the Study

The relevance of this study is its application of a therapeutic procedure, and the evaluation of that procedure, in terms of the therapeutic outcome. The value of the brief therapy procedures in terms of time, energy and expense, should lie in its applicability in a variety of situations. The consequences of the application of the procedures and their effectiveness in the hands of many therapists needs to be demonstrated. This study will not only add to the existing knowledge in the area, but will also explore the ease or difficulty inherent in the application of techniques consistent with the second order Change Model.

CHAPTER II

Literature Review

The intent of this chapter is to illustrate the development of the framework adopted for this study. A review of the assumptions of paradoxical interventions from several different models is presented. Implications of the principles of open systems as opposed to closed or linear systems as applied to psychotherapy are explored. Some aspects of the change framework are questioned and modifications to the framework are offered.

Behavioral Techniques

In the late 1920's, Dunlap applied the technique of negative practise to undesirable habits in order to extinguish the habit (Dunlap, 1946; Raskin & Klein, 1976). The technique required the client to practice his symptom, under therapist prescribed conditions, involving periods of practice, and client expectations of positive change. The intent was formulated as "bringing under voluntary control responses that have been involuntary." (Dunlap 1946, p.194). More recently, favorable results, judged by total extinction or decreased frequency of behaviors through negative practice, have been reported for treatment of tics, nocturnal head-banging, chewing, biting, and tearing behaviors (Yates, 1958; Walton, 1971; Wooden, 1974; Humphrey and Rachman, 1963).

The Behavioral technique of massed practice appears

paradoxical when used to extinguish habitual problem behaviors. The technique requires assiduous practice of the problem behavior until extinction occurs (Raskin & Klein, 1976). Behaviorists attribute the techniques success to drive reduction, dissipation of reactive inhibition and fatique. Supposedly, the cessation of practice serves as positive reinforcement to learning the opposite behavior (Yates, 1958; Mowrer, 1960; Humphrey and Rachman, 1963; Wooden, 1974).

Behaviorists also employ flooding or implosion techniques which appear paradoxical in nature. The technique floods the client with anxiety by presenting the stimuli or conditions most feared, without using relaxation as a counter conditioning agent (Stampfi and Levis, 1967). The client's anxiety is maintained until the client is "no longer able to respond with anxiety" (Goldstein, 1967, p.230). Behaviorists explain the resulting shifts in terms of protective inhibition, habit change due to prolonged exposure, or response competition (Goldstein, 1967; Wolpe, 1976; Gelder, 1975; Stern and Marks, 1973). Successful outcomes through implosion or flooding have been reported in the treatment of compulsive neurosis and agoraphobia (Rashman, Hodgson and Marks, 1971; Rashman, Hodgson and Marzellur, 1970; Wolpe and Ascher, 1975; Marks, Gaind and Watson, 1971).

Logotherapy-Paradoxical Intention

Frankl (1975) contends that anticipatory anxiety,

produced by anticipating the re-occurrence of one's symptom, locks the client into a vicious, self-sustaining circle where the very desire for avoidance paradoxically increases the occurrence of the symptom (Frankl, 1975; 1960). To shift the usual avoidance response and disrupt the feedback mechanisms, "paradoxical intention encourages the patient to do or wish to happen the very thing he fears" (Frankl, 1975, p.227). Shifting the client's attitude toward his "neurosis and it's symptomatic manifestation" defines the intent of the technique as well as the therapeutic criteria for evaluating outcome (Frankl, 1960, p.523).

Numerous descriptive studies report success in the treatment of obsessive compulsive and phobic patients with paradoxical intention (Gertz, 1962; Kaczanowski, 1967; Medlicott, 1969; Victor and Krug, 1967; Muller-Hegemann, 1963; Frankl, 1975; Lehembre, 1964; Ochs, 1968; Jacobs, 1972).

An investigation, in which an experimental obsessional thought was matched with a control obsessional thought in 10 patients was conducted by Solyom, Darza-Perz, Ledwige and Solyom (1972). A 50% success rate resulted after six weeks of applying paradoxical intention to the target thought. The study reports that symptom substitution or development of a new obsessional thought did not occur.

Directive Therapy

J. Haley. Haley (1963) employs paradox in a brief

therapy model in which interventions are directed at clearly defined symptoms. Within his communications model, he contends that symptomatic behavior serves as a means of defining or controlling a relationship. Haley states that, "most neurotic symptoms represent some type of extreme behavior which is qualified with an indication that the person cannot help it" (1963, p.5). Paradox then, arises out of a confusion or contradiction of two logical levels in communication - the report on the content level and the implicit command level. The defining or control process in the therapeutic relationship is a complex matter, as communication occurs on these two levels simultaneously (Bateson & Reusch, 1951).

Haley delineates an essential plan to his therapeutic paradoxes, resting first on the belief that the therapeutic relationship is seen as a benevolent framework, in which change will occur. If the therapist permits or encourages the patient to continue his symptomatic behavior, therapy provides a paradoxical ordeal which continues until the client shifts his behavior (Haley, 1963; Newton, 1968).

The intent is that of thwarting the client's efforts to gain interpersonal control through his symptomatic behavior (Haley, 1961, 1963). The techniques of symptom prescription, double-binds, and encouraging relapses, serve as maneuvers to maintain therapist control of the relationship. The control aspect in the therapeutic relationship

is the core ingredient of paradox in the model.

Milton Erickson. Erickson's methodological approach to therapy is replete with paradoxical interventions. The framework illustrates the potential "interpersonal impact of the therapist outside the client's awareness" (Haley, 1973, p.39). While Erickson's paradoxical interventions are directed at symptoms, the larger goal is to alter the client's present perceptions of reality (Weakland et al, 1974).

Erickson's theoretical position is based on growth and development involved in the lifestages of courtship, marriage, child rearing and old age. Problems or symptoms appear when the natural process for the individual or family becomes blocked or interrupted. For Erickson, a symptom change results in a basic change in the client's total system (Haley, 1973).

Erickson's paradoxical interventions illustrate the skill in accepting the client's language or reality perceptions, and utilizing this conceptual framework to produce change. When resistence or anxiety is operating as a block towards open communication, metaphoric communication circumvents this resistence as the "real" issue is never actually discussed. The implicit meaning or connection of the metaphor often occurs outside the client's conscious awareness, affording a re-framing of the problem. As a variation on communication with metaphors, Erickson may respond from within the metaphoric

reality presented by the client. To illustrate this, Erickson once approached a patient who called himself Jesus, inquiring about his past experience as a carpenter. He subsequently involved the patient in productive labour. Rather than interpret meaning behind a metaphor, Erickson will use the "extraordinarily complex statement" as the vehicle for client growth and change (Haley, 1973, p.29). Erickson's positive double-binds utilize the client's own inevitable behavior, tailored to fit an appropriate need or frame of reference for the client. The crux of his double-binds is the positive reframing of the reality of an event on a meta-level, while offering freedom of choice within that frame on the primary level (Erickson & Rossi, 1975).

Erickson's commitment to accepting what the client offers, reflects a firm belief in the individual's natural desire for growth. Client behaviors are encouraged as they represent a natural process at the time. The meaning or frame surrounding that process is altered to fit another equally appropriate frame. Thus, resistence, approaching change slowly or relapses are encouraged as natural experiences in the journey for change. Erickson's interventions being tailor made to fit the client's present process, place the responsibility for change in the client's hands.

Change Model

The Change Model proposed by Watzlawick et al. (1974) presents an integrated framework for conceptualizing the

relationship of persistence and change in human dilemmas. In the Change Model problems are seen as arising from the mishandling of everyday life situations. They are maintained by the ongoing behavior of the individual, and through interactions with significant others. If the problem maintaining behavior is changed or a new behavior pattern is substituted, then the original difficulty will be resolved, regardless of it's origin or duration (Watzlawick et al., 1974; Weakland, Fisch, Watzlawick and Bodin, 1974; Fisch, Weakland, Watzlawick, Segal, Hoebal and Deardorff, 1975). Therapy is not focused on a search for deep, underlying causes. Rather the focus is on altering those behaviors which perpetuate the problem system. The authors apply two theories from the field of mathematical logic to illustrate that change may occur on two distinct levels, called first and second order change (Watzlawick et al., 1974). First order change refers to changes in a system which do not effect or alter the overall structure of the system. Second order change represents a change of change or metalevel change where the premises governing the structure and operation of a system are altered, thus altering the system.

Problem Formation

A system which attempts numerous internal changes without achieving problem resolution is caught in a Game-Without-End (Watzlawick et al., 1974; Watzlawick, Jackson & Beavin, 1967). Games occur through three distinct

problem solving strategies. First, if denial is employed as the solution to an existing problem, then the problem becomes "greatly compounded by the problems created through its mishandling" (Watzlawick et al., 1974, p.46). If solutions are attempted to problems which are unchangeable, then a self-perpetuating problem system results. In this system, individuals become caught in a contradiction between their perceived image of reality and the way they would like it to be (Watzlawick, 1978). The struggle to close or bridge this gap, initiates a process where the attempted solutions become the problem. The third potential means of problem mishandling occurs when solutions are attempted at the wrong logical level. That is, attempting first order solutions when a second order change is required or applying second order change attempts when a first order solution is appropriate. When first order solutions, such as will power are employed to resolve problems regarding spontaneous or involuntary behaviors, then a paradoxical game results (Watzlawick et al., 1974). A similar result occurs when outside demands for a behavior and concurrent attitude change are made.

Once a Game-Without-End is in operation, second order change is required for its termination. Termination is not a move contained within the premises of the Game itself. It is a shift out of the Game framework or a jump to another level, causing a shift in premises of the Game (Watzlawick et al., 1974).

Problem Resolution

Paradoxical intervention. Symptom prescription techniques illustrate the paradoxical intervention strategy employed in the Change Model. However, as the problem is the attempted solution, then the solutions become the target of interventions. The solutions or symptoms vary, depending upon the nature of the problem. The interventions focus on blocking or interrupting the client's problem process, facilitating a shift in the old pattern.

The interventions effect a change at the meta-level where "the counterproductive attempts at solving the problem have created his Be Spontaneous paradox" (Watzlawick et al., 1974, p.87). The meta-level shift may be accomplished without the client behaviorally carrying out the symptom prescription. That is, the awareness of alternatives may alter the client's continued engagement in similar logical type solutions. In essence, the paradoxical techniques "lift the situation out of the paradox-engendering trap created by the self-reflexiveness of the attempted solutions and places it in a different frame (Watzlawick et al., 1974, p.83).

Reframing. Reframing represents a second major intervention style in the model designed to effect second order change. Reframing means "changing the emphasis from one class of an object to another equally valid class membership or, especially, introducing such a new class membership into the conceptualization of all concerned"

(Watzlawick et al., 1974, p.98). Reframing alters the reality perceptions of the problem on a meta-level. The meaning and consequences of an event are shifted, while the concrete facts or occurrence of the event are not explicitly altered (Watzlawick et al., 1974).

Reframing requires an understanding of the client's language and utilizing it in constructing a new framework. The client's language refers to the "values, beliefs, views and commitments" or client motivations (Fisch et al., 1975, p.18). The conceptual frame illustrating the problem may be conveyed non-verbally as well as verbally. Client motivation is increased and resistence decreased when interventions reflect the client's language.

Process interventions. Although the techniques of symptom prescription and reframing represent major intervention styles within the Change Model, spontaneous process interventions are also employed. These interventions focus upon a problem process occuring at a different level than the stated "problem". These "meta problems" are revealed during the process of therapy, as they frequently block change. The interventions follow the basic interventions styles described in the Change Model. For example, in situations where clients are experiencing difficulty revealing certain information, or when the therapist wants the client to accept some new idea, a one down position by the therapist may paradoxically facilitate this (Watzlawick et al., 1974). At times "therapeutic pessimism"

is employed to reframe a reluctance to improve, or to facilitate alternative perceptions of a hopeless situation. When clients desire change, but from a "no risk" position, a Devil's Pact is used, where acceptance or rejection of the Pact requires a risk. When change is slow in appearing, a "Go Slow" message is the intervention or choice. This technique, when used in conjunction with encouraging a relapse, allows for a positive reframing of all the shifts in the client's process. The uniqueness of the interventions may appear unrelated to the problem at the primary level, but are directly connected to it at a meta-level.

Treatment Plan

Watzlawick et al., (1974) describe a four step treatment plan through which they apply the change premises. The plan is implemented in a brief therapy context, with treatment limited to ten sessions.

Step one requires obtaining a specific and explicit report of the presenting problem, conveyed clearly through observable behavior patterns (Watzlawick et al., 1974; Fisch et al., 1975). This information "permits the crucial separation of problems from pseudo-problems" and providing a clear indication of the client's current functioning. These data provide the necessary precondition to investigate problem resolution.

In Step two, the attempted solutions which appear to be maintaining or exacerbating the problem are explored

(Watzlawick et al., 1974; Weakland et al., 1974). These data indicate where change to the system is needed, as well as which level of change should be attempted.

In Step three, a clear statement of the goals, phrased in terms of observable, concrete behavior, is required. A realistic, reachable goal prevents the therapist from compounding the problem through attempting wrong solutions, as well as functioning to "minimize any possibility of uncertainty or denial later," (Weakland et al., 1974, p.54). The exercise of establishing concrete realistic goals may be therapeutic both in instances where "utopian" expectations represent the problem, and by conveying a sense of optomism to the client.

The final step is the treatment plan, is the formulation and implementation of a therapeutic course of action (Watzlawick et al., 1974; Weakland et al., 1974; Fisch et al., 1975). Problem resolution requires interventions focused at blocking the attempted solutions, and altering the client's conceptual framework.

Evaluation of Therapy

Weakland et.al. (1974) present results from an evaluation of 97 cases. Three outcome categories are described: (a) complete relief of the complaint, 39 cases or 40%, (b) clear but not complete relief of the complaint, 31 cases or 32%, and (c) little or no such change, 27 cases or 28%. Therapy was evaluated from client responses to specific questions regarding the achievement of the

treatment goal, present status of the presenting problem, the need for further therapy, spontaneous shifts, and status of the overall system. Success of treatment was defined as achieving the stated behavioral goal and resolution of the presenting complaint. Cases were considered failures or partially successful if: (a) the goal was reached, considerable improvement was noted, but complete resolution of the presenting complaint was not attained. (b) Or, due to the vagueness of the stated goal, it's achievement remained uncertain. (c) Or, the goal was achieved without causing a system shift or a system shift occured without achieving the stated goal. Changes observed were credited to treatment due to the brevity of treatment, past refractorness of the presenting complaint, and observations of behavior change immediately following particular intervention. The average length of treatment was seven sessions.

Principles of Open Systems

Open systems are characterized by a dynamic interaction of parts and process, in such a manner that isolating a single variable responsible for a linear causal sequence is not possible (Von Bertalanaffy, 1966; 1968; Scheflen, 1963; 1966; 1968; Watzlawick, Beavin & Jackson, 1967; Bateson, 1970). Attributing meaning to one variable in isolation only obscures or alters the meaning of the total process, and leads to the construction of an imaginary context in which to view that valuable. To understand the

significance of any phenomena requires that it be viewed within its original context, with consideration being given to all the relevant completed circuits (Bateson, 1970). The therapeutic relationship, by virtue of the living organisms which comprise it, functions as an open system. This context represents an integration of both therapist and client systems. If one variable is given meaning without consideration of its total context, the result is a closed model.

In open systems, a stimulus does not cause a reaction to occur, rather it modifies an ongoing process in some manner (Von Bertalanffy, 1966, 1968). Further, end states can neither be determined by input stimuli, nor the systems initial conditions. Open systems move towards increasing order and differentiation rather than removing differences or moving towards entrophy to reduce tension. These principles suggest that in therapy, predictions of outcome from knowledge of initial states, attribution of a process to a particular intervention, and explanation of change through either linear or closed feedback models is not appropriate.

Implications and Critique of Models

In Dunlap and the Behaviorists' Models, symptoms represent learned behaviors. The purpose of therapy is to teach an incompatable behavioral response to the symptom evoking stimuli. Therapy is judged successful when the stimuli evokes a response of an opposite nature, eg.

tension replaced with relaxation. Thus, a behavior is shifted in response to a specific stimuli. This linear nature of the change blocks the potential for second order shifts. On the primary level, the client still responds to the initial stimuli, only in an opposite manner. Thus, on the meta-level, the client's overall system is still governed by that particular premise. In contrast to open systems, these models evaluate change by comparison with the client's initial behavior. Shifts other than prescribed behavioral shifts are not considered in the evaluation of client change.

Frankl (1975) requires an attitude change towards one's symptom as the necessary condition for paradoxical intention to be successful. The pre-determined criteria implies a closed system approach, where predictions of process reactions are made. In contrast to Frankl's model, the process may shift in unpredictable ways, but still lead to problem resolution. The intention aspect in Frankl's model limits the natural evolving process of that system. Strict adherence to the model's tenets implies that if a client's symtomatic behavior, but not attitude has shifted, and problem resolution has occured, therapy would not be considered successful. Thus, the larger goal could be achieved, but with limited acceptance.

The belief that a specific outcome results from a specific intervention assumes a linear causal chain. This excludes the context in which that intervention is given.

That is, communication occurs simultaneously on two levels, the verbal and non-verbal, making isolation of the critical variable difficult, if not impossible.

Watzlawick et. al. (1974) describe a paradoxical game arising when outside demands for an attitude change are imposed. With Frankl's system, as an attitude change is desired, an expectation of this may bind the therapist and client into a paradoxical game. That is, demands to experience the appropriate attitude to one's symptom make the task that much more impossible. A problem requiring second order change arises from applying solutions of an incorrect logical order. The purpose of any therapy model is not to develop new problem systems for a client, yet these types of assumptions may lead to that result.

Haley is adament that therapy will be successful only if therapist control is maintained. As the client maintained control of past relationships through symptomatic behavior then the posing of therapeutic paradoxes alters the controlling outcome. The assumptions, however, force the therapeutic relationship into closed systems model. That is, the direction of therapy is dependent upon the therapists frame of reference or interpretation of the purpose of client behaviors. Haley (1963) recognizes this dilemma and its potential for "perpetuating a conflictual relationship" (p.18).

The binding quality of the model if further illustrated in Haley's contention that the purpose of communication is

to establish control or define a relationship. This assumption applies to communication at the class level, including any class member. While symptomatic behavior represents an extreme form of control, non-symptomatic communication serves the same purpose -- to define or control. Thus, on a meta-level, a shift in style of communication does not necessarily alter the presmises governing the client's system. However, Haley contends that shifts in the therapist client relationship represent changes in the client's classification system with respect to his symptomatic behavior. As the client's perceptions shift, changes in other interpersonal relations can occur. These changes do appear reflective of second-order changes.

Erickson's methodological approach follows an open systems framework. Interventions arise from the naturally occuring process of the client, implying they are not pre-determined by the therapist. Erickson's purpose in therapy is to promote the clients' natural tendencies to grow and develop along their life course. The non-specificity of this allows multi-directional and multi-dimensional shifts to occur. The therapy system evolves spontaneously through accepting the client's conceptual frame as an integral part of the systems parameter rather than fitting the client's system into a pre-determined therapeutic frame. While techniques are focused upon symptoms, they impact more than the problem system. In doing so, second order shifts for the client are possible. The flexibility of

approach, acceptance of client's framework and natural process, and lack of therapeutic predictions reflect practical implementations of open systems principles.

Although the Change model follows open systems concepts, areas regarding its implementation reflect closed systems concepts. Closed system concepts are illustrated by the treatment plan. The plan implies a model where successful and end states appear more important than the client's ongoing process. To evaluate therapy as unsuccessful when problem resolution had occured, but the concrete goal was not reached is inconsistent. Goals are established at the beginning of therapy. They logically reflect issues concerning the initial, present status of the system. In open systems, however, end states or termination points cannot logically be determined from initial conditions. To evaluate therapy with data gathered from initial conditions, implies that the therapeutic process follows a logical path where outcome predictions are established. This is not the case with open systems.

Watzlawick et.al. (1974) indicate that failure often rests in the intervention chosen and evaluations of this "enable us to devise an improved plan" (p.115). Further, therapeutic change is attributed to planned interventions by "observation of behavior change immediately following particular interventions" (Weakland et al., 1974, p.163). The message implied is that a particular intervention or

package of interventions is directly responsible for change and final outcome. In open systems however, a stimulus serves to modify the ongoing process. That process is open to impact from virtually everything in the therapeutic encounter. In essence, spontaneous interventions and interplay of sub-systems not directly related to the problem system, may effect the process along with planned interventions. What contributes to the process shift cannot be attributed to one variable but must be viewed in the context of everything that is occuring.

Conclusions

Watzlawick et. al. (1974), in summarizing their model, state "as long as client and therapist both stay within the frame set by the former, the problem is bound to persist. Many different solutions can be attempted within this frame, but they invariably lead to the same outcome, namely zero second order change" (p.157). The examination of the models presented suggests that the converse of the above statement is equally true. That is, certain therapeutic assumptions may bind the therapist and the client in such a frame where zero second order change occurs. The limitations appear when therapist perceptions define the nature of the change, and how and why it occurs. Speculation, in retrospect, may offer useful directions, while pre-determination of outcome appears to bind the therapy system into a locked cause. The integration of open systems concepts to the change model requires

flexibility with regards to the treatment plan. While the treatment plan facilitates a clarity of concerns for both therapist and client, it arises from a description of the initial status of the problem system. In the therapeutic encounter other sub-systems not designated as the problem system are involved. The treatment plan isolates and structures interventions focused upon specific shifts in the problem system. It seemingly disregards the interplay and potential effectiveness of utilizing alternate sub-systems as vehicles for change. Spontaneous interventions arising as these sub-systems emerge may play as much a part in effecting shifts as do the strategic planned interventions. The process, in open systems, evolves in unpredictable ways to handle tension. This process, may not logically follow the course established in the treatment plan. Thus, the initially established goals of therapy may be meaningless in evaluating outcome. However, they do serve a useful function in illustrating change or movement. Their function in open systems of an interactional nature may be better served by viewing them as process markers rather than end state goals.

In summary, for the model implemented in this study equal concern will be focused upon potential impact of spontaneous interventions as to interventions which relate directly to the treatment plan. Further, the success or failure of treatment will be based on the use of goals as process markers rather than as desired end states.

CHAPTER III

The Plan of the Study

The content of chapter three deals with the rationale and procedures for this study.

Rationale

Neale and Liebert (1973) indicate that the merit of the single case study arises when it serves as "a prototypical example, to demonstrate important methods or procedures, and to provide an account of unusual phenomenon" (p.144). Its worth in laying the ground work for therapists by illustrating a unique framework, particularly when the framework may provide additional hypothesis concerning human behavior is advocated and encouraged by other researcher (Dukes, 1965; Shontz, 1965; Keisler, 1971; Bergen and Strupp, 1972). Due to the recent emergence of the Change model by Watzlawick et. al. (1974) and the limited research with the model, this study functions as a prototypical example. The use of transcribed tapes to illustrate and investigate a method and procedure is not unique. Carl Rodges used a similar procedure in demonstrating non-directive therapy (Shontz, 1965). The exploration of the model's effectiveness in a single case is an important purpose of this study. While each therapy encounter represents unique and unusual phenomena, what is specific to this study is the uniqueness of the proposed model. The model utilizes the assumptions of the Change

model, integrated into an open systems framework.

The researcher recognizes the inherent limitations of the single case study which preclude its use as evidence to confirm theoretical hypotheses. This authors intent is not to confirm the theoretical assumptions proposed by Watzlawick et. al. (1974) per se. Specifically, the intent is to investigate, through application the strengths and weaknesses of the integrated model proposed by this study.

Procedure

Treatment Plan

The four step treatment plan outlined by Watzlawick et. al. (1974) and Weakland et. al. (1974) was implemented in this study. That is, a clear description of the problem was obtained, followed by an exploration of previous and currently attempted solutions. Goals, as process markers, not evaluative measures, were established. Finally, interventions were applied to interrupt or block the previous pattern of attempted solutions. Because of the interactional nature of the therapy encounter, two classes of interventions were employed. Planned interventions arising from the stated problem were designed to facilitate second order shifts in the system. Rather than being pre-planned, these interventions arose from data emerging each week regarding the clients present process and conceptual framework. The second class of interventions emerged spontaneously without forethought to the

treatment plan. These interventions arose from the immediacy of the therapy process. They receive equal attention in analyzing the process.

Subjects

The subjects were a married couple, J age 26 and his wife M, age 29. They were a self-referral to counselling, assigned to this therapist due to an opening in his schedule. The couple volunteered to be participants in the research study.

Number of Sessions

In keeping with the format of "Brief Therapy" the couple was informed that the research component would be limited to between one and twenty sessions (Haley, 1963; Barton, 1971). Therapy was concluded in eleven sessions, over a four month period. The couple attended ten sessions jointly, with M attending one session individually. Sessions were scheduled on a weekly basis lasting from 1 to 1.5 hours in length. All sessions were audio-taped, and written transcripts of the sessions were made to facilitate analyzing the data.

Follow-Up Interview

Four months after termination of therapy, a follow-up interview was held. The interview followed the format employed by Weakland et. al. (1974). The following questions were asked in an attempt to evaluate the effectiveness of the treatment plan and the present status of the couple's system. The questions, phrased in the therapist's

language were:

1. How have things been for you for the last four months?

2. After coming here for the sessions, do you feel that the goals have been met?

3. What would you see as being the major differences in your relationship now, that is how is your relationship different now than what it was when you first came in?

4. At this point, could you see yourself ever, needing or wanting to come back in for further counselling in terms of that the original problem was?

5. Since September, have any new problems arisen?

From these major questions, minor inquiries arose to elicit further clarification or elaboration of the responses. A discussion of the responses is presented in Chapter four.

Therapist

The therapist is a male, M.Ed. student, currently enrolled in Counselling Psychology at the University of Alberta, Edmonton and is experienced in the use of second order change techniques.

CHAPTER IV

Therapy Process

The purpose of this chapter is to illustrate the application of the treatment approach, and its impact on the problem system. First, a description of the problem system, the attempted solutions and the goals for change are presented. Next, the therapy process is described. The major interventions connected to the process are presented. Data describing the problem system at the termination of therapy and from the follow-up interview are also presented. The results are reported in an abbreviated form, illustrating the highlights and significant aspects of the process. Selected exerpts from the tape transcripts are included to supplement the descriptions.

Background Information

The couple sought therapy to improve their deteriorating relationship. Therapy was a final alternative, as they felt unsuccessful in changing or coping with their particular problem area. The problem concerned depressions which J experienced and their impact on the couple's relationship.

At age 26, J had experienced depressed moods for the past 13 years. While the depressions varied in severity and duration, the frequency had increased substantially during the past year. He felt helpless to control them, stating: "I don't have any idea when they're coming on

really, and when they end, when they go away . . . it could happen at any particular time, I can't really say when, or where, or how it's going to happen." During these depressions, J was very lethargic, withdrawn, unable to concentrate, tired and easily frustrated. Other areas were effected by his depressions as well. He stated that he could not function at work, so he would refuse to go, plus he lost all desire to interact with others and so he would withdraw from social contacts. M stated that during these periods she worried, was generally unhappy, and at times felt uncertain about the stability of their marriage. As well, her ability to concentrate was diminished so that her work was negatively effected. Her major concern was the feeling of guilt she experienced, regardless of her responses to him during his depressions.

Problem Descriptions

During a depressed period the couple became trapped in a cyclical process. That is, M was reluctant to discuss issues or express her feelings. She felt expressing them would increase J's depressed state. As her frustration increased, her patience and tolerance for his decreased. He responded to this by expressing helplessness at controlling his state, and feeling more depressed. His feelings of guilt increased, as he believed that his state was a reaction to what he perceived as a lack of understanding and concern. In essence, the pattern of the couple functioned as a self-fulfilling prophecy. M and J

had not been successful in changing this pattern.

Attempted Solutions

Exploration of the couple's attempts at altering the depressions, produced the following solution pattern. J described them as, "M will try and help me and I'll try, and she'll try and cheer me up or try and get me to do something, or get up and help out, like around the house or do anything, just to try and get feeling happy. Quite often it won't work, and quite often I feel more depressed as a result of anybody's efforst to try and cheer me up or try and draw me out of it." This pattern is an example of a solution of a first order nature. J described another pattern.

"I suppose there probably are a lot of things I could be doing, could try to do. Although to try to just keep myself busy, or whatever, quite often any attempt that I would do for that just doesn't seem to do that much good. It doesn't matter what I do, it's not going to help, oh, the thing is always going to be present."

In short, attempts at using willpower, denial or "busy work" to solve the problem appeared to exacerbate condition. As the couple continued to respond in this pattern, they were trapped into a Game Without End.

Goals as Process Markers

In order to identify shifts in process, and provide directions for therapy, the couple described the following

goals. The therapist suggested that they function as "directions to be worked towards, not end points." M stated that she wanted to convey more feelings of trust and confidence towards J, and she wanted to express herself without feeling guilty about making J more depressed. J stated that he wanted to handle various situations without allowing himself to become depressed, to feel more confident in himself, and to be able to help himself through a depression. When asked specifically what would be different in achieving these goals, both focused upon shifts in J's depressions. The overall treatment goal became to experience a shift either in duration, frequency, or intensity of the depressions, and to gain a feeling of control, rather than helplessness, over them.

The Therapy Process

Session one. The focus in this session was to obtain an understanding of the problem and attempted solutions. The information about the problem was presented in the preceeding sections. At the conclusion of the session, two requests were made of the couple. J was asked to keep a written log of the number, severity, duration, and circumstances of all further depressions. M was asked to ignore J during these periods, and to try and feel guilty in the process. Both agreed to follow these requests.

Session two. In regards to the previous intervention M had some difficulty ignoring J during a depression, but

she did not feel as guilty during these times. She viewed the task in a positive light, in part because it was suggested. She also felt optomistic because J was writing about the depressions. J stated that he experienced only one major depression and a few minor ones. He was concerned whether his eight pages of detailed notes fulfilled the therapist's expectations. The therapist expressed amazement at J's ability to labour over such a tedious task while being depressed. For the following week, J was encouraged to bring on a depression during time away from work. This fit his previous time patterns. He was encouraged to do some planning of this event during the week. M was encouraged to ignore J as much as possible and to busy herself with feeling guilty. The immediate response to these requests resembled shock, turning to laughter, and then acceptance.

Session three. A fire in the couple's home during the proposed depression time disrupted the intervention process. J performed admirably during the crisis, was astonished that he had not become depressed in the situation. The therapist shared J's amazement over this control. M was surprised as J performed beyond her expectations. J reported feeling that a depression was waiting in the wings, now that the worst was over. While J acknowledged some ability in controlling his behavior during the crises, he felt that he couldn't fight the depression off any longer. He was encouraged to let it happen, to bring in

on and relieve himself of the tension and pressure he had coped with. The session ended with that intervention.

Session four. A number of shifts appeared in conjunction with the previous week's intervention. First, J had little success maintaining and furthering his depressed state as requested. However, he viewed this as a sign of failure. Two days later, he felt very frustrated and angry over his contined struggle to fight off a depression. M responded by encouraging J to let it happen, to get depressed rather than fight it. Although J eventually did get depressed, he did not think he "brought it on." He appeared quite frustrated with this event. The therapist encouraged him to proceed at a slower pace, and cautioned him that anymore "behavior flips like that" might confuse the critical issues. He responded positively, indicating that he was surprised at his increased energy level during the depression. He reported that that was not a pattern in previous depressions. He was encouraged to bring on another depression. He felt he was experiencing trouble obtaining the proper intensity, so he was encouraged to physically act out the motions of being lethargic. He was to attempt this at a time when he was not at work.

Session five. J followed the directions superbly, achieving a grand depression during the scheduled time. He felt particularly successful over this, and informed the therapist of a critical sign that convinced him. The sign was that M became extremely angry and frustrated with J,

and informed him of her feelings. M stated that although this reaction was different from past patterns, she felt no guilt in behaving that way. The therapist reflected how this was a sure sign of success, which J acknowledged. While J felt he had some control, he was uncertain as to its long term significance. The therapist reminded J to go slow, and suggested he test out this control by bringing on a really good, two day depression. J felt that that was a good idea.

Session six. Due to prior commitments, J did not attend the session. In response to the previous intervention, M reported that he experienced some difficulty bringing the depression on, but that he was still trying. M felt that she was doing too much for J, and neglecting her own needs. She decided to experiment with changing this pattern of J being so dependent on her. She felt this deprived him of opportunities to increase his confidence and responsibility. The therapist accepted and encouraged her decision, adding that doing too many good deeds may increase the receiver's feelings of weakness. She reflected on the difficulty of changing this pattern, as "it's become a habit now." The therapist suggested that if she did slip back into the old ways, she could always go full force in that direction, becoming super-wife. She agreed to keep that thought in mind, as it could be useful.

Session seven. J was very frustrated over the course of the sessions, and his lack of success with the inter-

ventions. In response to the previous intervention, J reported that he had a bit of a depression on the days planned, but it was cut short due to responses of those around him. He felt they were implying that if he wanted to be depressed to do it, but not to expect sympathy from them. He felt this response had hindered him from being depressed and he became angry instead. He was frustrated because he could not seem to have a good depression, as the process was being interrupted before he'd experience it completely. The therapist's fear of losing the couple from therapy, prompted a rather unique intervention. Rather than explicitly reflect J's behavior as an example of a desired shift, M and J were asked how they planned to occupy the impending void in their relationship when the depressions ceased. They could not respond, as the thought was totally foreign to them. A decision was made to shift the focus of the sessions away from the depressions, to give J some time to integrate all that had happened.

Session eight. There was a two week interval between sessions seven and eight, due to J entering hospital for a minor operation. J reported a number of cognitive and behavioral changes towards the depressions. During his hospital stay he experienced few minor down periods, but saw them as just reactions to his situation. He did not consider them true depressions. He believed that he used the depressions to handle situations which were uncomfortable for him, but being depressed didn't make the problems

disappear. Instead, it compounded them. The therapist replied, "Well, I guess if they serve a purpose you might be able to convince yourself you have some control." J's immediate physical and verbal response suggested the message had connected. He grinned, sat bolt uptight, and replied, "Yea - whether I realize it or not, I do. Maybe I do control them and never really realized it." He was asked to have a depression during the following week. M responded first with, "Don't you mean bring one on?"; to which the therapist replied, "no, just have one." J laughed, and said, "that's easy."

Session nine. J was beaming when he entered the session, reporting that, rather than one, he chose to have two depressions that week. The excitement was shared by the therapist, who remarked that J had not really followed the instructions, he'd overdone them a bit. He responded with, "yea, I guess I did, but they were not as intense or prolonged . . .". The light heartedness of the comment, coupled with his grin, again implied a shift in process. M shared in the enthusiasm, remarking that their relationship had also changed. She did feel some fear over the suddeness of this change, thinking they could easily slip back into their old ways. The therapist replied that this was natural whenever one does not feel in control of a change. The couple was asked to experiment with relapsing, "to discover this control." They consented, although M did so with some hesitation. J agreed to have a

depression, as he felt it would be an important part of the relapse.

Session ten. The couple reported that they did slip back into their old patterns one evening. They became impatient, not listening to the other's point of view, and did not try to understand one another. They reported that after the relapse, they felt a trifle ridiculous, but more aware of their behavior. M felt the experience was beneficial and suggested that it would be good to do it again in the future. She felt more confident with the relationship, and their control in it. She felt particularly optimistic that "the problems that were there before haven't manifested themselves." She felt more relaxed when facing a difficulty, and believed that it allowed them to handle problems differently. J reported that he was free of depression during the week. When the therapist commented "Well, let's not have too many of those now," he replied, "yes, it would be very dull." Due to holidays, the next session was scheduled three weeks later. The couple was reminded to go slow.

Session eleven. The couple reported a number of positive shifts during the interim between sessions ten and eleven. First, they reported there were no relapses. She stated that she did not feel "uptight or worried about their relationship," and she had more confidence. She stated that she could now depend upon J for support, and in return gave J more support. J felt the relationship

was stronger. He also stated, "I can control my depressions now." M added, "he can laugh at himself now." Both felt that the patterns of relating to each other, and to the depressions had shifted. J's self-confidence had changed. He had applied for a new job, one for which he had no prior training or experience. He was interviewed for the position, and was told that when a job appeared he would be considered. He stated that acquiring the job was not his main interest. He was excited as he had approached an unfamiliar situation with confidence. The couple felt that the changes achieved were those they desired. The therapist suggested that a final session be held to review the experience and gather data about goals. The couple was told that if termination was felt to be too hasty a decision, therapy would continue. Both felt that termination was appropriate.

Termination Interview

As the couple decided further therapy was not required, the termination session focused on gathering information regarding the status of the problem system. The focus was a review of the major goals, and description of the status of their relationship.

Goals. M reported that she still felt some guilt at times when J was down, but the frequency and intensity of the feelings had decreased. She reported that she expressed her thoughts more often to J, but at times

experienced some difficulty in formulating and presenting them. She felt that she over-analyzed situations and responses too often, and so was trying to relax more, to not jump to conclusions, and assume blame or guilt. She stated that, "instead of panicking and getting all uptight now, I kind of expect things to be bad sometimes, so I don't worry so much about it."

In discussing the depressions, J continued to be free of feeling depressed. He stated that the possibility of having a depression remained, but that he did not worry about that. He reported feeling confident and capable and could handle his depressions. He stated, "the possibility of getting a bad depression is getting more and more remote because I'm handling it a little differently." He described the difference as "decisions I've made to take action, to pull myself out, instead of just letting it happen and just sitting like a lump of jello." He thought that a shift in his feelings of control occured prior to session seven, at which time he questioned what more could occur. He felt his confidence over having control increased noticeably in the remaining sessions. J cited his job search, and the fact that he felt comfortable talking on the telephone, as examples of his increased confidence.

Shifts in the relationship. M and J could not clearly explain how they handled problems differently, both reported feeling that the pattern was different. M cited how J took the initiative in discussing problem areas,

and listened to her point of view more often. Both felt they shared more positive feelings towards each other. They felt their communication had improved, but were both committed to developing it further. M felt stronger, more sure of the relationship. J added that they had learned how to cope for themselves. Both thought they analyzed situations less, were less defensive and withdrawn, and were more relaxed. Both conveyed a sense of optimism towards the future, stating that they "were on the right track now" and the "rest of the work is up to us."

Follow-up Interview

This section focuses on the responses to the questions asked in the follow-up interview. The information reflects the status of this system, four months after termination of therapy.

1. How have things been for you the last four months?

The immediate response from the couple was positive, "no complaints, things are very good." One month after terminating therapy, they reported experiencing a crisis period. They described it as a serious downslide, where they considered ending their relationship. This period of tension lasted for a week. The couple could not explain how they resolved the issues, rather they felt that "it was this way one day, and the next day it was different." Both agreed that they did not make a conscious decision to "make the relationship work" and could not explain why their feelings towards each other had changed "almost

overnight." The perception the couple proposed, was that the set-back represented the void in their relationship caused by the shifts in J's depressions. M stated, "we seemed to have a lot of time with nothing to do, there was that empty space, that we didn't know how to fill." In retrospect, both saw the experience as a test of whether they would revert back to their old ways. They felt the experience had generated a renewed strength and commitment during this time, deciding that they would tackle the crisis themselves.

2. Do you feel the goals have been met?

Both gave positive responses to this question. Other than experiencing a mild depression during their crisis, J reported that, "there hasn't been any depressions. There have been times when before I would have become depressed, but I didn't." He still felt in control of the depressions. He was able to recognize events that might lead to a depression, and took measures to either lessen it or ward it off completely. J stated that the whole idea seemed quite foreign now, adding, " didn't consciously think about it anymore." When questioned about feelings of guiilt, M also replied, "it's hard to talk about, because except maybe in October, I can't remember feeling guilty at all."

3. Is your relationship different now?

Both reported feeling stronger in their relationship. They felt they were communicating on a "good level," where

instead of reacting to one another, "we're listening and trying to understand." M felt more confidence in herself and more respect for J. As a result of their crisis in October, M recognized a change in the way she handled J's depressions. She stated, "I feel now, with something that would throw him into a depression, instead of thinking that and immediately panicking and wondering what I could do to cheery him up, I say yes, that was crummy for you, and let him talk to me about it." Both reported feeling more at ease showing and receiving affection with each other.

4. Any other changes in the relationship?

When asked if there were any other specific changes in their relationship, the couple reported that they were more involved with church activities and J was taking flying lessons. They were also attending seminars, and planning sessions to prepare them to be teacher/missionaries in Africa. They arrived at this decision after careful evaluation of their present lifestyle. They concluded that neither was ready for early retirement and this offered them an opportunity to travel and experience different cultures. The training program was a year in length, which allowed them ample time to access their decision.

5. Would you want to come back in for further counseling in terms of original problem?

Both responded negatively to this question. J indicated that the depressions were not a problem now. He recognized the potential for them to become a problem

in the future. M shared J's thoughts, adding, "this is really a test for us, if we can't make it through on our own, well, we won't have much of a marriage, always relying on others." Both expressed feelings of confidence that their relationship would continue to improve.

6. Have any new problems arisen?

Both initially referred to their experience in October, stating that since then a new problem has not developed to replace the depression.

CHAPTER V

Discussion

This was an exploratory study to generate ideas leading to an integrated Model of Change, and Open Systems. The discussion in this chapter focuses on ideas regarding the process of change to the individual problem system and the relationship system, as well as issues within the therapy system which appeared to facilitate or inhibit therapeutic change. The chapter concludes with a discussion of future research issues.

Practical Changes to the Problem System

The results from the follow-up interview indicated that the initial problem had occured only once in a 5½ month-time span. This decrease in frequency was accompanied by practical shifts in the process of dealing with the initial problem. It was observed that as J's perceptions changed, his process shifted from a passive, reactive mode, to engaging in more dynamic, action oriented behaviors. As he shifted to confronting problem issues, and actively structured alternatives, the frequency of the depressions lessened. M, on the other hand, moved slowly through a process of disengagement from the problem system. Her process was marked by changes in her response pattern to J's depressions. Her responses changed from trying to cheer him up, to trying to ignore him, to encouraging and then eventually empathising with

and acknowledging J's option to feel depressed.

These changes, when combined with perceptual shifts about the problem system, suggest that a change of a second order nature had occured. In the follow-up interview, the impact of the problem system was negligible. The couples' energies were no longer focused on the problem. The premises of the Game which had governed their relationship had disappeared and were not replaced with the utopian belief of remaining problem free forever. These results lend support to the tenets of the treatment approach. The integration of open system concepts with the Change model afforded a flexibility of approach and a way to conceptualize the process upon termination of therapy.

Shifts in the Relationship

An issue in this study was whether change in one problem system would have any impact on other levels of the relationship. Although the focus was more on shifts in the problem system, distinct shifts in the lifestyle pattern were apparent at the time of follow-up. One month after termination, the couple experienced a serious crisis, threatening termination of their relationship. While their initial response was reminiscent of past problem solving measures, neither remained in this pattern. Individually, they chose not to employ first order, try harder, solutions. Rather, they viewed this event as a positive marker in the growth of their relationship. As they shifted their perceptions of the problem, the problem also changed. In short, they employed a

solution process congruent with second order change principles, a definite shift away from the type of problem solving methods that were typical when they entered therapy.

Other practical changes were evident in the couple's lifestyle. Their participation in social and leisure time activities increased. The relationship process appeared more active and dynamic as they sought out new experiences and became involved in uncharted courses. The increased energy and lifestyle shifts correspond, in time, with the couple's decreasing concern about the depression. The relationship did not appear bound by traditional premises or past rules, as unusual and unexpected options were being explored. This corresponds with Erickson's (1973) position, that once a symptom is shifted, the process of the total system is freed, allowing it continue growing and developing. In this case, the couple were exploring a number of options, rather than remaining within a restricted, traditional set of choices. The shift appears characteristic of a second order change.

Therapy Issues

Through the course of therapy, a number of facilitating and inhibiting factors to the therapy process emerged. Although impression about these factors are inferential, they did have a pronounced impact upon the therapist.

The process towards problem resolution appeared facilitated by a combination of planned and spontaneous interventions. In the therapist;s perceptions, the planned

interventions appeared to facilitate behavioral shifts in process, but at times, the reality perceptions or conceptual frame did not appear to shift correspondingly. On the other hand, conceptual shifts appeared connected to spontaneous interventions. At times, their impact appeared to be immediate, as observed by changes in body posture, facial expressions, speech patterns, or statements about the problem. In other instances, the impact was not immediately observed, but its influence on the process appeared later. The variations observed in these responses and impact tend to support the contention that change cannot accurately be attributed to single interventions, or sets of interventions. Rather, the process may be impacted by numerous factors.

An important function of the spontaneous interventions appears related to their communication of acceptance and understanding of the client's conceptual frame. The use of the client's language did convey a sense of trust and acceptance of their belief system. In return, their resistence or difficulty in experiencing alternative frames appeared to decrease.

The shift in perceptions about the depressions illustrates a unique issue. The depressions shifted in intensity and frequency, and J was feeling in control before session eight. However, his immediate response to a spontaneous reflection in that session suggested that a further shift in process occured. Perhaps a pattern had

connected for him, forming a different gestalt or frame. This was not an event predicted by either the therapist or J, and yet for both, the perceptions of the depressions after that instance were radically different.

Therapy could have been terminated in session seven, and considered partially successful from the criteria proposed by Weakland et. al. (1974). Due to the experiences which followed after session seven, it is felt that valuable information would have been lost had termination occured at that time. The process of change proceeded in small stages, and appeared facilitated through continuation in therapy until the couple felt confident about terminating. It is proposed, that strict adherence to simply "goal achievement" as the criteria for termination may not be facilitating in some instances.

The fact that the therapist was using the process for a study imposed further limitations. At times, feelings about acquiring results, locked the therapist into a no-lose course. These limits frequently inhibited the spontaneity and flexability of the encounter and detracted from the effective implementation of the integrated treatment model. The therapist's desire to be a good therapist was made clear in session seven. The disclosure of the pressure and frustration over not always feeling very helpful, resulted in an unpredictable shift in the encounter. Once the therapist stopped needing to be helpful, the couple began to rely more on their own competencies and

resources. The paradoxical impact of this one down shift was neither planned, nor expected. The entirely therapeutic process appeared more spontaneous, after this shift. A new level of humour appeared in the sessions, particularly in the perceptions of the problem. As the therapist relaxed more, the couple became more active. In short, the therapeutic encounter underwent a second order change, as inhibiting factors to the process were revealed. The therapist's process appears important in facilitating growth and change in the total therapeutic relationship. Two issues within the treatment plan are related to the limitations of the research focus and its impact upon the therapist. The treatment plan focuses on one major sub-system, the problem system. The significance of the problem was elevated out of proportion through the exclusion of a focus on other sub-systems, resulting in the near premature termination of therapy. While in this study, the fault may lie within the therapist and his focus, it was observed that the sessions followed a more natural open systems model once this focus shifted. The focus upon specified goals, as criteria for successful outcome in the Change Model may, in part, blind the therapist to the total context. In the integrated model in this study, the goals were not specifically defined, and attention was not explicitly focused on them during the therapy encounter. However, they served a useful function as they marked shifts in process, as demonstrated by

observations of behaviors within the encounter, and by reports of events outside the encounter. The process occured without the couple reporting about achieving the initially stated goals. It appears that the goals reflect system concerns at the point of entering therapy, and as the system evolved in unpredictable ways, the initial goals, when achieved, may have little importance or relevance to a change in process. However, if the therapy process continues to focus on the initial goals, the natural open contect of the therapeutic encounter can be limited.

Future Research

The ideas generated from this study are encouraging illustrations of an integration of open system concepts with second order change principles. However, they also imply a paradox with regards to future research. The present traditional cause and effect methodologies focus on manipulation and control of dependent and independent variables in order to assume a predictability of outcome. With the open systems concepts, there are only independent variables, and predicting outcome would paradoxically bind the system into a predetermined course. At this time, it would appear that a preferred bases for research in this area, should be one of discovery, rather than proof. Bateson (1966) suggests that highly abstract theories tend to be self validating and not amenable to traditional research methodologies. An exploration and development of alternative methodologies suggests a direction for future

investigation.

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